

**ATTENTION**

**MEDICAID PREFERRED PHYSICIANS AND CHILDREN PROGRAM (PPAC)**

**Applicants to PPAC must complete this ADDENDUM to *Application for Enrollment as a Medical or Dental Specialist***

- INSTRUCTIONS:**
- (1) Type or print the information in the space provided.
  - (2) Attach required documentation.
  - (3) Sign and date the Assurances.
  - (4) Submit completed Application, Addendum and required documentation to:

eMedNY  
 P.O. Box 4610  
 Rensselaer, New York 12144

**SECTION A – IDENTIFYING INFORMATION**

1. Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

2. License No.: \_\_\_\_\_ State: \_\_\_\_\_

3. Please complete **IF YOU ARE** an enrolled Medicaid Provider:

MMIS #: \_\_\_\_\_ National Provider Identifier (NPI): \_\_\_\_\_

**SECTION B – PRACTICE INFORMATION**

4. If you employ/use the services of one or more nurse practitioners and/or physician assistants, please give name(s) and license(s) below:

<u><b>NAME</b></u>	<u><b>LICENSE NO.</b></u>	<u><b>STATE</b></u>
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Attach additional pages as necessary.

**SECTION C – ACTIVE HOSPITAL ADMITTING PRIVILEGE (Check ONE):**

5. \_\_\_\_\_ I have an active admitting privilege at an accredited hospital. A copy of my hospital appointment letter is attached.

\_\_\_\_\_ I do not have an active hospital privilege as above for circumstances that I believe merit consideration. I have completed Section E – EXCEPTION.

**SECTION D – ASSURANCES**

6. I recognize that I continue to be bound by the rights, obligations, duties or interests accrued, incurred or conferred as a result of my enrollment in the New York State Medicaid Program.
7. As a preferred primary care physician, I assure the provision of comprehensive medical care services to Medicaid patients below the age of twenty-one years, in accordance with generally accepted standards of medical practice and, for well visits, in accordance with the requirements of the Child/Teen Health Program.
8. As a preferred primary care physician, I agree to provide medical care coordination as a part of my care, such medical care coordination to include at a minimum the scheduling of elective hospital admissions, where possible, assistance with emergency admissions, management of and/or participation in hospital care and discharge planning, scheduling of referral appointments with written referral as necessary and with request for follow-up report, scheduling for necessary ancillary services, telephone notification of the Medicaid patient's local department of social services when transportation services are necessary to insure access to health care, and the maintenance of a complete medical record to include but not be limited to notation of referrals and hospitalizations, and copies of test results and reports.
9. I assure that patients with Medicaid will be free to choose their primary care physician and will be free to choose, from among qualified providers, the specialist to whom they will be referred.
10. As a participating specialist, I assure that I will provide medical care coordination as necessary to these patients. Such medical care coordination should include at a minimum the scheduling of elective hospital admission, management of participation in hospital care and discharge planning, periodic follow-up reports to the referring primary care provider regarding the plan for and outcomes of specialist services, scheduling for necessary ancillary services, and telephone notification of the Medicaid patient's local department of social services when transportation services are necessary to insure access to health care.
11. As a primary care physician I assure that I will maintain twenty-four hour telephone coverage which will include timely access to a practitioner qualified to respond to the Medicaid patient's health concerns. I recognize that this requirement cannot be met by a recording referring patients to the emergency room.

12. I assure that I will request as necessary from the NYS Department of Health, and display conspicuously on my premises, designated informational materials that serve to inform the public regarding Medicaid eligibility and services for persons under twenty-one years of age and for pregnant women.
13. I assure that I will notify the NYS Department of Health within thirty (30) days of circumstances resulting in *ineligibility* to continue this agreement and/or my *inability* to perform the activities and services required under this agreement.
14. I recognize that the State may determine new visit types and rates during the term of this agreement and that the new visit types and rates may supersede those available at the time of this agreement.
15. I assure that I will abide by all reasonable policies, procedures, and instructions provided by the State to implement and execute the Preferred Physicians and Children Program, and will bill Medicaid in accordance with the reimbursement methodology established by the State.
16. I recognize that the New York State Department of Health may cancel my participation in the Preferred Physicians And Children Program at any time, giving me not less than thirty (30) days written notice that on or after the date therein specified, my participation will end. I accept that cause for cancellation of my participation in the Preferred Physicians And Children Program will include but not be limited to my failure to comply with these assurances, including but not limited to failure to accurately bill Medicaid under the reimbursement methodology established.
17. I recognize that I may request cancellation of my participation in the Preferred Physicians And Children Program when there are extenuating circumstances, giving to the NYS Department of Health not less than thirty (30) days written notice. I assure that such cancellation will include a description of the basis for the request. I agree to continue to provide and/or arrange services for patients up to the date of termination. I assure that I will assist patients to maintain continuity of care, provide them with information to assist them to transfer their care; and make timely transfer of the records upon request.
18. I accept that upon my designation by the New York State Department of Health to participate in the Preferred Physician and Children Program, these Assurances will be effective and may continue in effect thereafter with the consent of both parties and so long as Federal financial participation is available. I accept that services rendered prior to my enrollment will not be eligible for reimbursement through the Preferred Physician and Children Program.

19. PRINT NAME \_\_\_\_\_

20. SIGNATURE \_\_\_\_\_

21. DATE \_\_\_\_\_

**SECTION E – EXCEPTION REQUEST INFORMATION**

1. Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_
2. (a) License Number: \_\_\_\_\_ (b) State: \_\_\_\_\_
3. IF YOU ARE an enrolled Medicaid provider, please provide your  
MMIS #: \_\_\_\_\_ National Provider Identifier (NPI): \_\_\_\_\_

**CHECK EITHER 4(A) OR (B) AND (C)**

4. (A) \_\_\_\_\_ Attached is a brief summary of the circumstances that support my request for waiver of the requirement to have an active hospital admitting privilege.

(B) \_\_\_\_\_ I have attached a copy of a letter of active hospital appointment other than admitting privilege.

\_\_\_\_\_ I have attached documentation of an agreement between myself and a primary care physician who is licensed to practice in New York, has an active hospital admitting privilege and will monitor and provide continuity of care to my patients who are hospitalized.

AND

(C) \_\_\_\_\_ I have attached my *curriculum vitae* and proof of current medical malpractice insurance coverage and two letters of reference, each from a physician who can attest to my qualifications as a practicing physician.